FOR OHF USE

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0036079

Facility Name: WARREN PARK NURSING PAVILION

Address: 6700 N. DAMEN AVENUE (Number) CHICAGO (City) 60646 (Zip Code)

County: COOK

Telephone Number: (773) 465-5000 **Fax #** (773) 743-5983

IDPA ID Number: 363693973001

Date of Initial License for Current Owners: 03/01/90

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve Lavenda **Telephone Number:** (847) 236 - 1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/01 to 12/31/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) _____

(Title) _____

Paid Preparer

(Signed) See Accountants' Compilation Report Attached (Date)

(Print Name and Title) RICHARD S. SGARLATA, C.P.A.

(Firm Name & Address) Frost, Ruttenberg & Rothblatt, P.C.
111 Pfingsten Road, Suite 300 Deerfield, IL 60015

(Telephone) (847) 236-1111 Fax# (847) 236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number WARREN PARK NURSING PAVILION # 0036079 Report Period Beginning: 01/01/01 Ending: 12/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	127	Skilled (SNF)	127	46,355	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	127	TOTALS	127	46,355	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	6,953	595	2,331	9,879	8
9	SNF/PED					9
10	ICF	24,250	646	152	25,048	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	31,203	1,241	2,483	34,927	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 75.35%

D. How many bed-hold days during this year were paid by Public Aid?
NONE (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NA

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 3/10/90

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 3/10/90 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 11 and days of care provided 1610

Medicare Intermediary MUTUAL OF OMAHA

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 12/31/01 Fiscal Year: 12/31/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number WARREN PARK NURSING PAVILION # 0036079 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	190,518	22,736	6,720	219,974		219,974		219,974			1
2	Food Purchase		194,314		194,314	(44,366)	149,948	(141)	149,807			2
3	Housekeeping	114,062	17,570		131,632		131,632		131,632			3
4	Laundry	35,675	10,384		46,059		46,059		46,059			4
5	Heat and Other Utilities			84,421	84,421		84,421	640	85,061			5
6	Maintenance	49,973	23,653	32,594	106,220		106,220	(813)	105,407			6
7	Other (specify):*							975	975			7
8	**TOTAL General Services**	390,228	268,657	123,735	782,620	(44,366)	738,254	661	738,915			8
	B. Health Care and Programs											
9	Medical Director			4,200	4,200		4,200		4,200			9
10	Nursing and Medical Records	964,874	87,469	22,453	1,074,796		1,074,796	(7,538)	1,067,258			10
10a	Therapy		70	5,870	5,940		5,940		5,940			10a
11	Activities	73,236	3,366	3,218	79,820		79,820	(806)	79,014			11
12	Social Services	89,280		8,060	97,340		97,340	(1,404)	95,936			12
13	Nurse Aide Training							100	100			13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,127,390	90,905	43,801	1,262,096		1,262,096	(9,648)	1,252,448			16
	C. General Administration											
17	Administrative	110,114		26,640	136,754		136,754	121,542	258,296			17
18	Directors Fees											18
19	Professional Services			218,462	218,462	(2,017)	216,445	(187,137)	29,308			19
20	Dues, Fees, Subscriptions & Promotions			21,711	21,711		21,711	(13,251)	8,460			20
21	Clerical & General Office Expenses	84,262	1,722	48,161	134,145		134,145	36,803	170,948			21
22	Employee Benefits & Payroll Taxes			380,473	380,473	44,366	424,839	(19,986)	404,853			22
23	Inservice Training & Education											23
24	Travel and Seminar			3,260	3,260		3,260	714	3,974			24
25	Other Admin. Staff Transportation			4,910	4,910		4,910	91	5,001			25
26	Insurance-Prop.Liab.Malpractice			112,626	112,626		112,626	2,885	115,511			26
27	Other (specify):*							17,993	17,993			27
28	**TOTAL General Administration**	194,376	1,722	816,243	1,012,341	42,349	1,054,690	(40,346)	1,014,344			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,711,994	361,284	983,779	3,057,057	(2,017)	3,055,040	(49,333)	3,005,707			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**
NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number WARREN PARK NURSING PAVILION #0036079 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			30,888	30,888		30,888	21,757	52,645			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			36,890	36,890		36,890	193,497	230,387			32
33	Real Estate Taxes			119,923	119,923	2,017	121,940	(1,792)	120,148			33
34	Rent-Facility & Grounds			376,671	376,671		376,671	(376,671)				34
35	Rent-Equipment & Vehicles			9,523	9,523		9,523	6,174	15,697			35
36	Other (specify):*											36
37	**TOTAL Ownership**			573,895	573,895	2,017	575,912	(157,035)	418,877			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		67,713	37,466	105,179		105,179	(1,239)	103,940			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			69,533	69,533		69,533		69,533			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		67,713	106,999	174,712		174,712	(1,239)	173,473			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,711,994	428,997	1,664,673	3,805,664		3,805,664	(207,607)	3,598,057			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number WARREN PARK NURSING PAVILION # 0036079 Report Period Beginning: 01/01/01 Ending: 12/31/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	(78,129)	30		9
10	Interest and Other Investment Income	(30,309)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(69)	02		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions	(3,075)	20		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(960)	21		24
25	Fund Raising, Advertising and Promotional	(8,418)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(39,469)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (160,429)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(47,178)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (47,178)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (207,607)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

WARREN PARK NURSING PAVILION

ID# 0036079

Report Period Beginning: 01/01/01

Ending: 12/31/01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Capitalized Repairs & Maintenance	$ (6,510)	6	1
2	PPA-FOOD	(72)	2	2
3	PPA-MAINTENANCE	(1,585)	6	3
4	PPA-NURSING SUP	(1,573)	10	4
5	PPA-CONTRACT NURSING	(496)	10	5
6	PPA-ACTIVITIES	(806)	11	6
7	PPA-SOCIAL WORK	(1,404)	12	7
8	PPA- DUES, SUBS	(264)	20	8
9	PPA-OFFICE	(811)	21	9
10	PPA-EMP. BENEFITS	(19,986)	22	10
11	DISCOUNTS EARNED	(2,516)	10	11
12	BANK CHARGES	(927)	21	12
13	COPE) POLITICAL CONT.	(2,519)	20	13
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STATE OF ILLINOIS

Summary A

Facility Name & ID Number WARREN PARK NURSING PAVILION # 0036079 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary													1
2	Food Purchase	(141)											(141)	2
3	Housekeeping													3
4	Laundry													4
5	Heat and Other Utilities			640									640	5
6	Maintenance	(8,095)		3,317	3,965								(813)	6
7	Other (specify):*			685		290							975	7
8	**TOTAL General Services**	(8,236)		4,642	3,965	290							661	8
	B. Health Care and Programs													
9	Medical Director													9
10	Nursing and Medical Records	(4,585)							(2,953)				(7,538)	10
10a	Therapy													10a
11	Activities	(806)											(806)	11
12	Social Services	(1,404)											(1,404)	12
13	Nurse Aide Training			100									100	13
14	Program Transportation													14
15	Other (specify):*													15
16	**TOTAL Health Care and Programs**	(6,795)		100					(2,953)				(9,648)	16
	C. General Administration													
17	Administrative			(26,640)	148,182								121,542	17
18	Directors Fees													18
19	Professional Services			(187,137)									(187,137)	19
20	Fees, Subscriptions & Promotions	(14,276)	150	875									(13,251)	20
21	Clerical & General Office Expenses	(2,698)		35,625	3,876								36,803	21
22	Employee Benefits & Payroll Taxes	(19,986)											(19,986)	22
23	Inservice Training & Education													23
24	Travel and Seminar			714									714	24
25	Other Admin. Staff Transportation			91									91	25
26	Insurance-Prop.Liab.Malpractice			2,885									2,885	26
27	Other (specify):*			5,745		12,248							17,993	27
28	**TOTAL General Administration**	(36,960)	150	(167,842)	152,058	12,248							(40,346)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(51,991)	150	(163,100)	156,023	12,538			(2,953)				(49,333)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number WARREN PARK NURSING PAVILION # 0036079 Report Period Beginning: 01/01/01 Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(78,129)	97,172	2,714									21,757	30
31	Amortization of Pre-Op. & Org.													31
32	Interest	(30,309)	222,253	1,553									193,497	32
33	Real Estate Taxes		(3,300)	1,508									(1,792)	33
34	Rent-Facility & Grounds		(376,671)										(376,671)	34
35	Rent-Equipment & Vehicles			6,174									6,174	35
36	Other (specify):*													36
37	TOTAL Ownership	(108,438)	(60,546)	11,949									(157,035)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation													38
39	Ancillary Service Centers								(1,239)				(1,239)	39
40	Barber and Beauty Shops													40
41	Coffee and Gift Shops													41
42	Provider Participation Fee													42
43	Other (specify):*													43
44	TOTAL Special Cost Centers								(1,239)				(1,239)	44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	(160,429)	(60,396)	(151,151)	156,023	12,538			(4,192)				(207,607)	45

Facility Name & ID Number WARREN PARK NURSING PAVILION # 0036079 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
SEE ATTACHED		SEE ATTACHED		SEE ATTACHED		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	34	RENTAL INCOME	$ 376,671	WARREN PARK, L.L.C.		$	$ (376,671)	1
2	V	20	TRUST FEES		WARREN PARK, L.L.C.		150	150	2
3	V	32	INTEREST EXPENSE		WARREN PARK, L.L.C.		222,253	222,253	3
4	V	30	DEPRECIATION		WARREN PARK, L.L.C.		97,172	97,172	4
5	V	33	REAL ESTATE TAX EXPENSE		WARREN PARK, L.L.C.		117,900	117,900	5
6	V	33	R/E TAX OVER-ACCRUAL	121,200				(121,200)	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 497,871			$ 437,475	$ * (60,396)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WARREN PARK NURSING PAVILION # 0036079 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	5	UTILITIES	$	DYNAMIC HEALTH CARE CONS.	100.00%	$ 640	$ 640	15
16	V	6	REPAIRS & MAINT.				3,317	3,317	16
17	V	7	EMP.BEN. - GEN. SERVICES				685	685	17
18	V	13	NURSES AIDE TRAINING				100	100	18
19	V	19	PROFESSIONAL FEES				1,440	1,440	19
20	V	20	DUES AND SUBSCRIPTIONS				875	875	20
21	V	21	CLERICAL & GENERAL				35,625	35,625	21
22	V	24	SEMINARS AND TRAVEL				714	714	22
23	V	25	ADMIN. STAFF TRANS.				91	91	23
24	V	26	INSURANCE				2,885	2,885	24
25	V	27	EMP.BEN. - GEN. ADMIN.				5,745	5,745	25
26	V	30	DEPRECIATION				2,714	2,714	26
27	V	32	INTEREST				1,553	1,553	27
28	V	33	REAL ESTATE TAXES				1,508	1,508	28
29	V	35	EQUIPMENT RENTAL				6,174	6,174	29
30	V								30
31	V	17	MANAGEMENT FEE	26,640				(26,640)	31
32	V	19	ACCOUNTING FEE	317				(317)	32
33	V								33
34	V	19	BOOKKEEPING FEES	188,260				(188,260)	34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 215,217			$ 64,066	$ * (151,151)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WARREN PARK NURSING PAVILION # 0036079 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	6	MAINT. CMP. - D. NEHMER	$	DYNAMIC HEALTH CARE CONS.	100.00%	$ 3,965	$ 3,965	15
16	V	10	NURSING CMP - SUE G.						16
17	V	17	ADMIN. CMP. - M. MAUER				24,527	24,527	17
18	V	17	ADMIN. CMP. - M. AARON				33,270	33,270	18
19	V	17	ADMIN. CMP. - F. AARON						19
20	V	17	ADMIN. CMP. - S. GOLDSTEIN						20
21	V	17	ADMIN. CMP. - S. KOPLIN						21
22	V	17	ADMIN. CMP. - D. MAGAFAS						22
23	V	17	ADMIN. CMP. - E. CASSON						23
24	V	17	ADMIN. CMP. - S. BOGEN				67,800	67,800	24
25	V	17	ADMIN. CMP. - S. LEVY				8,610	8,610	25
26	V	17	ADMIN. CMP. - HOWARD ALTER						26
27	V	17	ADMIN. CMP. - NON-OWNER				13,975	13,975	27
28	V	21	CLERICAL CMP. - S. AARON				3,876	3,876	28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 156,023	$ * 156,023	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WARREN PARK NURSING PAVILION # 0036079 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	7	EMP. BEN.- D. NEHMER	$	DYNAMIC HEALTH CARE CONS.	100.00%	$ 290	$ 290	15
16	V	15	EMP. BEN.- SUE G.						16
17	V	27	EMP. BEN.- M. MAUER				1,566	1,566	17
18	V	27	EMP. BEN.- M. AARON				2,294	2,294	18
19	V	27	EMP. BEN.- F. AARON						19
20	V	27	EMP. BEN.- S. GOLDSTEIN						20
21	V	27	EMP. BEN.- S. KOPLIN						21
22	V	27	EMP. BEN.- D. MAGAFAS						22
23	V	27	EMP. BEN.- E. CASSON						23
24	V	27	EMP. BEN.- S. BOGEN				4,794	4,794	24
25	V	27	EMP. BEN.- S. LEVY				1,195	1,195	25
26	V	27	EMP. BEN.- HOWARD ALTER						26
27	V	27	EMP. BEN.- NON-OWNER				1,879	1,879	27
28	V	27	EMP. BEN. - S. AARON				520	520	28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 12,538	$ * 12,538	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WARREN PARK NURSING PAVILION # 0036079 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10A	THERAPY	$ 5,870	DYNAMIC REHAB CONSULTANTS, L.L.C.	100.00%	$ 5,870	$	15
16	V	19	PROFESSIONAL FEES		DYNAMIC REHAB CONSULTANTS, L.L.C.	100.00%			16
17	V	22	EMPLOYEE BENEFITS		DYNAMIC REHAB CONSULTANTS, L.L.C.	100.00%			17
18	V	39	ANCILLARY SERVICES	36,602	DYNAMIC REHAB CONSULTANTS, L.L.C.	100.00%	36,602		18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 42,472			$ 42,472	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WARREN PARK NURSING PAVILION # 0036079 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	10	NURSING & MEDICAL SUPPLY	$ 6,656	PHARMCOR, L.L.C.	100.00%	$ 6,656	$	15
16	V	19	PROFESSIONAL FEES		PHARMCOR, L.L.C.	100.00%			16
17	V	21	CLERICAL & GENERAL	215	PHARMCOR, L.L.C.	100.00%	215		17
18	V	22	EMPLOYEE BENEFITS	412	PHARMCOR, L.L.C.	100.00%	412		18
19	V	39	ANICILLARY EXPENSE	30,140	PHARMCOR, L.L.C.	100.00%	30,140		19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 37,423			$ 37,423	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WARREN PARK NURSING PAVILION # 0036079 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V	10	MEDICAL SUPPLIES	14,262	LINCOLN MEDICAL SUPPLIES, INC.	100.00%	11,309	(2,953)	16
17	V	39	ANCILLARY EXPENSE	5,984	LINCOLN MEDICAL SUPPLIES, INC.	100.00%	4,745	(1,239)	17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$ 20,246			$ 16,054	$ * (4,192)	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WARREN PARK NURSING PAVILION # 0036079 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WARREN PARK NURSING PAVILION # 0036079 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WARREN PARK NURSING PAVILION # 0036079 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V			$			$	$	15
16	V								16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	V								25
26	V								26
27	V								27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$	$ *	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number WARREN PARK NURSING PAVILION # 0036079 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	MAURY AARON	OWNER	ADMIN	19.685%	SEE ATTACHED	2.9	5.74%	Alloc-Dynamic	$ 33,270	17-7	1
2	MARSHALL MAUER	OWNER	ADMIN	6.299%	SEE ATTACHED	2.5	4.92%	Alloc-Dynamic	24,527	17-7	2
3	SHARON AARON	RELATIVE	CLERICAL	0	SEE ATTACHED	2.46	6.01%	Alloc-Dynamic	3,876	21-7	3
4	SHEILA BOGEN	OWNER	ADMIN	14.96%	SEE ATTACHED	31.50	70.00%	Alloc/Salary	80,690	17-7/17-1	4
5	SHARON BOGEN	RELATIVE	RECEPTIONIST	0	NONE	3	100.00%	SALARY	1,570	21-1	5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 143,933		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number WARREN PARK NURSING PAVILION # 0036079 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number WARREN PARK NURSING PAVILION # 0036079 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC HEALTH CARE CONS.
Street Address: 3359 W. MAIN STREET
City / State / Zip Code: SKOKIE, IL. 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	5	UTILITIES	PATIENT DAYS	577,359	15	$ 10,580	$	34,927	$ 640	1
2	6	REPAIRS & MAINT.	PATIENT DAYS	577,359	15	54,834	37,633	34,927	3,317	2
3	7	EMP.BEN. - GEN. SERVICES	PATIENT DAYS	577,359	15	11,326		34,927	685	3
4	13	NURSES AIDE TRAINING	PATIENT DAYS	577,359	15	1,650		34,927	100	4
5	19	PROFESSIONAL FEES	PATIENT DAYS	577,359	15	23,811		34,927	1,440	5
6	20	DUES AND SUBSCRIPTIONS	PATIENT DAYS	577,359	15	14,469		34,927	875	6
7	21	CLERICAL & GENERAL	PATIENT DAYS	577,359	15	588,891	487,646	34,927	35,625	7
8	24	SEMINARS AND TRAVEL	PATIENT DAYS	577,359	15	11,803		34,927	714	8
9	25	ADMIN. STAFF TRANS.	PATIENT DAYS	577,359	15	1,502		34,927	91	9
10	26	INSURANCE	PATIENT DAYS	577,359	15	47,685		34,927	2,885	10
11	27	EMP.BEN. - GEN. ADMIN.	PATIENT DAYS	577,359	15	94,969		34,927	5,745	11
12	30	DEPRECIATION	PATIENT DAYS	577,359	15	44,866		34,927	2,714	12
13	32	INTEREST	PATIENT DAYS	577,359	15	25,667		34,927	1,553	13
14	33	REAL ESTATE TAXES	PATIENT DAYS	577,359	15	24,936		34,927	1,508	14
15	35	EQUIPMENT RENTAL	PATIENT DAYS	577,359	15	102,054		34,927	6,174	15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,059,043	$ 525,279		$ 64,066	25

Facility Name & ID Number WARREN PARK NURSING PAVILION # 0036079 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC HEALTH CARE CONS.
Street Address: 3359 W. MAIN STREET
City / State / Zip Code: SKOKIE, IL. 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	MAINT. CMP. - D. NEHMER	WGHTD. AVG. HOURS	40	12	62,194	62,194	3	3,965	1
2	10	NURSING CMP - SUE G.	WGHTD. AVG. HOURS	40	1	45,894	45,894			2
3	17	ADMIN. CMP. - M. MAUER	WGHTD. AVG. HOURS	40	13	398,821	398,821	2	24,527	3
4	17	ADMIN. CMP. - M. AARON	WGHTD. AVG. HOURS	45	12	521,536	521,536	3	33,270	4
5	17	ADMIN. CMP. - F. AARON	WGHTD. AVG. HOURS	45	6	191,700	191,700			5
6	17	ADMIN. CMP. - S. GOLDSTEIN	WGHTD. AVG. HOURS	50	3	161,003	161,003			6
7	17	ADMIN. CMP. - S. KOPLIN	WGHTD. AVG. HOURS	45	8	71,993	71,993			7
8	17	ADMIN. CMP. - D. MAGAFAS	WGHTD. AVG. HOURS	45	8	81,938	81,938			8
9	17	ADMIN. CMP. - E. CASSON	WGHTD. AVG. HOURS	38	1	47,846	47,846			9
10	17	ADMIN. CMP. - S. BOGEN	WGHTD. AVG. HOURS	45	3	96,858	96,858	32	67,800	10
11	17	ADMIN. CMP. - S. LEVY	WGHTD. AVG. HOURS	55	13	139,807	139,807	3	8,610	11
12	17	ADMIN. CMP. - HOWARD ALT	WGHTD. AVG. HOURS	40	1	9,000	9,000			12
13	17	ADMIN. CMP. - NON-OWNER	WGHTD. AVG. HOURS	45	13	219,069	219,069	3	13,975	13
14	21	CLERICAL CMP. - S. AARON	WGHTD. AVG. HOURS	40	13	63,022	63,022	2	3,876	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 2,110,681	$ 2,110,683		$ 156,023	25

Facility Name & ID Number WARREN PARK NURSING PAVILION # 0036079 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC HEALTH CARE CONS.
Street Address: 3359 W. MAIN STREET
City / State / Zip Code: SKOKIE, IL. 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	7	EMP. BEN.- D. NEHMER	WGHTD. AVG. HOURS	40		4,545		3	290	1
2	15	EMP. BEN.- SUE G.	WGHTD. AVG. HOURS	40		3,924				2
3	27	EMP. BEN.- M. MAUER	WGHTD. AVG. HOURS	40		25,461		2	1,566	3
4	27	EMP. BEN.- M. AARON	WGHTD. AVG. HOURS	45		35,957		3	2,294	4
5	27	EMP. BEN.- F. AARON	WGHTD. AVG. HOURS	45		22,028				5
6	27	EMP. BEN.- S. GOLDSTEIN	WGHTD. AVG. HOURS	50		20,193				6
7	27	EMP. BEN.- S. KOPLIN	WGHTD. AVG. HOURS	45		16,504				7
8	27	EMP. BEN.- D. MAGAFAS	WGHTD. AVG. HOURS	45		17,632				8
9	27	EMP. BEN.- E. CASSON	WGHTD. AVG. HOURS	38		11,976				9
10	27	EMP. BEN.- S. BOGEN	WGHTD. AVG. HOURS	45		6,849		32	4,794	10
11	27	EMP. BEN.- S. LEVY	WGHTD. AVG. HOURS	55		19,408		3	1,195	11
12	27	EMP. BEN.- HOWARD ALTER	WGHTD. AVG. HOURS	40		1,068				12
13	27	EMP. BEN.- NON-OWNER	WGHTD. AVG. HOURS	45		29,449		3	1,879	13
14	27	EMP. BEN. - S. AARON	WGHTD. AVG. HOURS	40		8,457		2	520	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 223,451	$		$ 12,538	25

Facility Name & ID Number WARREN PARK NURSING PAVILION # 0036079 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: DYNAMIC REHAB CONSULTANTS, L.L.C.
Street Address: 3359 W. MAIN STREET
City / State / Zip Code: SKOKIE, IL. 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10A	THERAPY	DIRECT ALLOCATION						5,870	1
2	19	PROFESSIONAL FEES	DIRECT ALLOCATION							2
3	22	EMPLOYEE BENEFITS	DIRECT ALLOCATION							3
4	39	ANCILLARY SERVICES	DIRECT ALLOCATION						36,602	4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 42,472	25

Facility Name & ID Number WARREN PARK NURSING PAVILION # 0036079 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization PHARMCOR, L.L.C.
Street Address 3116 S. OAK PARK
City / State / Zip Code BERWYN, IL 60402
Phone Number (708)795-7701
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	10	NURSING & MEDICAL SUPPLY	DIRECT ALLOCATION						6,656	1
2	19	PROFESSIONAL FEES	DIRECT ALLOCATION							2
3	21	CLERICAL & GENERAL	DIRECT ALLOCATION						215	3
4	22	EMPLOYEE BENEFITS	DIRECT ALLOCATION						412	4
5	39	ANICILLARY EXPENSE	DIRECT ALLOCATION						30,140	5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 37,423	25

Facility Name & ID Number WARREN PARK NURSING PAVILION # 0036079 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: LINCOLN MEDICAL SUPPLIES, INC.
Street Address: 3359 W. MAIN STREET
City / State / Zip Code: SKOKIE, IL. 60076
Phone Number: (847) 679-8219
Fax Number: (847) 679-7377

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1										1
2	10	MEDICAL SUPPLIES	DIRECT ALLOCATION						11,309	2
3	39	ANCILLARY EXPENSE	DIRECT ALLOCATION						4,745	3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 16,054	25

Facility Name & ID Number WARREN PARK NURSING PAVILION # 0036079 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number WARREN PARK NURSING PAVILION # 0036079 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number WARREN PARK NURSING PAVILION # 0036079 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number WARREN PARK NURSING PAVILION # 0036079 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related											
	Long-Term											
1	DEVON BANK		X	MORTGAGE	$31,390	6/95	$ 2,921,000	$ 2,151,078	5/2010	10.00%	$ 222,253	1
2												2
3												3
4												4
5												5
	Working Capital											
6	MANUFACTURES BANK		X	WORKING CAPITAL				400,000			26,283	6
7	MANUFACTURES BANK		X	WORKING CAPITAL				314,000			10,607	7
8												8
9	TOTAL Facility Related				$31,390		$ 2,921,000	$ 2,865,078			$ 259,143	9
	B. Non-Facility Related*											
10	See Supplemental Schedule										(28,756)	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$ (28,756)	14
15	TOTALS (line 9+line14)						$ 2,921,000	$ 2,865,078			$ 230,387	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number WARREN PARK NURSING PAVILION # 0036079 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
1	ALLOC DYNAMIC	X		INTEREST EXPENSE			$	$			$ 1,553	1
2	INTEREST INCOME										(30,309)	2
3												3
4												4
5												5
6												6
7												7
8												8
9												9
10												10
11												11
12												12
13												13
14												14
15												15
16												16
17												17
18												18
19												19
20												20
21							$	$			$ (28,756)	21

Facility Name & ID Number WARREN PARK NURSING PAVILION # 0036079 Report Period Beginning: 01/01/01 Ending: 12/31/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report.		$ 124,000	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ 118,131	2
3. Under or (over) accrual (line 2 minus line 1).		$ (5,869)	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 124,000	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)		$ 2,017	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ 120,148	7

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	1996	119,803	8
	1997	119,043	9
	1998	121,156	10
	1999	120,343	11
	2000	119,923	12

2001 ACCRUAL = 2000 RE TAX EXPENSE 119,223 *1.03 = 124000

ALLOCATION FROM DYNAMIC $1,508

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME WARREN PARK NURSING PAVILION COUNTY COOK

FACILITY IDPH LICENSE NUMBER 0036079

CONTACT PERSON REGARDING THIS REPORT Steve Lavenda

TELEPHONE (847) 236-1111 FAX #: (847) 236-1155

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	11-31-302-043-0000	LTC PROPERTY	$ 72,215.00	$ 72,215.00
2.	11-31-302-008-0000	LTC PROPERTY	$ 47,708.00	$ 47,708.00
3.	10-23-404-059-0000	HOME OFFICE	$ 24,139.00	$ 1,460.00
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 144,062.00	$ 121,383.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? X YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number WARREN PARK NURSING PAVILION # 0036079 Report Period Beginning: 01/01/01 Ending: 12/31/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 43,400 B. General Construction Type: Exterior BRICK Frame _____ Number of Stories 3

C. Does the Operating Entity? [ ] (a) Own the Facility [X] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [X] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

NONE

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	FACILITY		1985	$ 158,750	1
2					2
3	TOTALS			$ 158,750	3

Facility Name & ID Number WARREN PARK NURSING PAVILION # 0036079 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4					$	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Various			1990	177,699		20	8,885	8,885	102,686	9
10	Various			1991	40,276		20	2,014	2,014	21,098	10
11	Various			1992	26,271		20	1,314	1,314	12,813	11
12	Various			1993	39,480		20	1,969	(1,969)	16,189	12
13	Various			1994	61,455		20	3,074	3,074	22,476	13
14	Various			1995	53,672		20	2,685	2,685	17,839	14
15	Various			1996	5,720		20	286	286	1,632	15
16	Various			1997	31,153		20	1,558	1,558	7,250	16
17								-		-	17
18								-		-	18
19								-		-	19
20								-		-	20
21								-		-	21
22								-		-	22
23								-		-	23
24								-		-	24
25								-		-	25
26								-		-	26
27								-		-	27
28								-		-	28
29								-		-	29
30								-		-	30
31								-		-	31
32								-		-	32
33								-		-	33
34								-		-	34
35								-		-	35
36								-		-	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number WARREN PARK NURSING PAVILION # 0036079 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$ -	$	$ -	37
38						-		-	38
39						-		-	39
40						-		-	40
41						-		-	41
42						-		-	42
43						-		-	43
44						-		-	44
45						-		-	45
46						-		-	46
47						-		-	47
48						-		-	48
49						-		-	49
50						-		-	50
51						-		-	51
52						-		-	52
53						-		-	53
54						-		-	54
55						-		-	55
56						-		-	56
57						-		-	57
58						-		-	58
59						-		-	59
60						-		-	60
61						-		-	61
62						-		-	62
63						-		-	63
64						-		-	64
65						-		-	65
66						-		-	66
67						-		-	67
68	Related Party Allocations (Page 12-REP & Page 12A-REP)		2,725,585	98,045		767	(97,278)	6,389	68
69	Financial Statement Depreciation			30,888			(30,888)		69
70	TOTAL (lines 4 thru 69)		$ 3,161,311	$ 128,933		$ 22,552	$ (110,319)	$ 208,372	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WARREN PARK NURSING PAVILION # 0036079 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 3,161,311	$ 128,933		$ 22,552	$ (106,381)	$ 208,372	1
2	ELEVATOR REPAIR	1998	9,737		20	487	487	1,867	2
3	ALTERATION TO OFFICE	1998	525		20	26	26	98	3
4	ALTERATION TO OFFICE	1998	893		20	45	45	169	4
5	HANDRAIL & BUMPER GU	1998	3,859		20	193	193	708	5
6	ROOF WORK	1998	1,755		20	88	88	323	6
7	NURSES STATION/RECEPTION	1998	26,365		20	1,318	1,318	4,723	7
8	CARPETING	1998	842		20	42	42	151	8
9	WOOD BORDERS	1998	2,290		20	115	115	412	9
10	ROOM SIGNS	1998	1,273		20	64	64	229	10
11	PAINTING AND DECOR	1998	465		20	23	23	84	11
12	HANDRAIL & BUMPER	1998	1,950		20	98	98	343	12
13	REMODELING-OFFICES	1998	10,000		20	500	500	1,750	13
14	REMODELING-OFFICES	1998	7,557		20	378	378	1,292	14
15	REMODELING-OFFICES	1998	13,335		20	667	667	2,279	15
16	REMODELING-OFFICES	1998	3,446		20	172	172	588	16
17	REMODELING-OFFICES	1998	419		20	21	21	72	17
18	BATHROOM-REMODELING	1998	4,457		20	223	223	743	18
19	DOOR SYSTEM	1998	1,009		20	50	50	167	19
20	REMODELING-NEW WALL	1998	3,740		20	187	187	608	20
21	DUCT & FIRE DAMPER	1998	5,390		20	270	270	878	21
22	NURSES STATION	1998	5,262		20	263	263	855	22
23	ELEVATOR DOORS	1998	1,631		20	82	82	273	23
24	BOILER	1998	971		20	49	49	98	24
25	SPRINKLER HEADS	1998	714		20	36	36	72	25
26	FIRE ALARM	1998	1,050		20	53	53	106	26
27	ALARM SYSTEM	1998	816		20	41	41	82	27
28	PAINTING AND DECOR	1998	18,655		20	982	982	1,964	28
29	SPRINKLER HEADS	1998			20	36	36	114	29
30	ELEVATOR REPAIRS	1998	900		20	45	45	143	30
31	FLOOR & CARPETING	1998	2,776		20	139	139	440	31
32	TUCK POINTING	1998	7,430		20	372	372	1,147	32
33	FIRE ALARM	1998	1,866		20	93	93	287	33
34	TOTAL (lines 1 thru 33)		$ 3,302,689	$ 128,933		$ 29,710	$ (99,223)	$ 231,437	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WARREN PARK NURSING PAVILION # 0036079 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 3,302,689	$ 128,933		$ 29,710	$ (99,223)	$ 231,437	1
2	WOOD TRIM	1998	1,510		20	76	76	228	2
3	SPRINKLER SYSTEM	1999	3,912		20	196	196	555	3
4	FIRE ALARM REPAIR	1999	986		20	49	49	139	4
5	SPRINKLER SYSTEM	1999	473		20	24	24	68	5
6	SPRINKLER SYSTEM	1999	941		20	47	47	129	6
7	EMERGENCY DOORS	1999	1,350		20	68	68	176	7
8	NEW DOOR	1999	2,900		20	145	145	375	8
9	FIRE DAMPERS	1999	848		20	42	42	84	9
10	FIRE DAMPERS	1999	2,351		20	118	118	295	10
11	FIRE DAMPERS	1999	2,357		20	118	118	295	11
12	WALK IN COOLER	1999	1,153		20	58	58	116	12
13	ELEVATOR REPAIR	1999	1,095		20	55	55	110	13
14	FIRE ALARM	1999	900		20	45	45	90	14
15	SEWAGE PUMP	1999	511		20	26	26	52	15
16	GLUEDOWN RUNNER	1999	855		20	43	43	86	16
17	EMERGENCY LIGHTS	1999	587		20	29	29	58	17
18	BOILER REPAIR	1999	800		20	40	40	80	18
19	EMERGENCY BATTERY LI	2000	4,800		20	240	240	460	19
20	REFRIGERATOR	2000	2,155		20	108	108	171	20
21	ELEVATOR UPGRADE	2000	2,182		20	109	109	154	21
22	THERAPY	2000	115,660		20	5,783	5,783	9,156	22
23	REMODEL ROOM & HALL	2000	13,178		20	659	659	1,043	23
24	ELEVATOR REPAIR	2000	1,000		20	50	50	67	24
25	PARALLEL BARS	2000	902		20	45	45	53	25
26	REMODELING ROOMS & HALLS	2000	12,215		20	611	611	713	26
27	BEAUTY SALON DOOR	2000	626		20	31	31	34	27
28	SEWER WORK	2000	2,350		20	118	118	128	28
29	WALLPAPER	2000	1,127		20	56	56	112	29
30	FIRE ALARM REPAIR	2000	3,353		20	168	168	336	30
31	BATHROOM FIXTURES	2000	561		20	28	28	56	31
32	INSTALLATION OF OUTL	2001	7,175		20	299	299	299	32
33	ELEVATOR REPAIR	2001	1,125		20	33	33	33	33
34	TOTAL (lines 1 thru 33)		$ 3,494,627	$ 128,933		$ 39,227	$ (89,706)	$ 247,188	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WARREN PARK NURSING PAVILION # 0036079 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12C, Carried Forward		$ 3,494,627	$ 128,933		$ 39,227	$ (89,706)	$ 247,188	1
2	DRAPERIES FOR RESIDE	2001	675		20	17	17	17	2
3	TILE	2001	1,139		20	33	33	33	3
4	WIRING ON A/C UNIT	2001	15,110		20	126	126	126	4
5	CABINETS	2001	10,150		20	85	85	85	5
6	ROOF REPAIRS	2001	3,909		20	33	33	33	6
7	WALLPAPER	2001	532		20	27	27	27	7
8	SPRINKLER SYSTEM	2001	923		20	46	46	46	8
9	FIRE ALARM REPAIR	2001	709		20	35	35	35	9
10	ELECTRICAL WORK	2001	625		20	31	31	31	10
11	FIRE ALARM REPAIR	2001	533		20	27	27	27	11
12	KITHCEN VENTILATOR	2001	752		20	38	38	38	12
13	FIRE PUMP REPAIR	2001	1,215		20	61	61	61	13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,530,899	$ 128,933		$ 39,786	$ (89,147)	$ 247,747	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WARREN PARK NURSING PAVILION # 0036079 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12D, Carried Forward		$ 3,530,899	$ 128,933		$ 39,786	$ (89,147)	$ 247,747	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
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16									16
17									17
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19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,530,899	$ 128,933		$ 39,786	$ (89,147)	$ 247,747	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WARREN PARK NURSING PAVILION # 0036079 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12E, Carried Forward		$ 3,530,899	$ 128,933		$ 39,786	$ (89,147)	$ 247,747	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,530,899	$ 128,933		$ 39,786	$ (89,147)	$ 247,747	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WARREN PARK NURSING PAVILION # 0036079 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12F, Carried Forward		$ 3,530,899	$ 128,933		$ 39,786	$ (89,147)	$ 247,747	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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17									17
18									18
19									19
20									20
21									21
22									22
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24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,530,899	$ 128,933		$ 39,786	$ (89,147)	$ 247,747	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WARREN PARK NURSING PAVILION # 0036079 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12G, Carried Forward		$ 3,530,899	$ 128,933		$ 39,786	$ (89,147)	$ 247,747	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,530,899	$ 128,933		$ 39,786	$ (89,147)	$ 247,747	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WARREN PARK NURSING PAVILION # 0036079 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12H, Carried Forward		$ 3,530,899	$ 128,933		$ 39,786	$ (89,147)	$ 247,747	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
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20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,530,899	$ 128,933		$ 39,786	$ (89,147)	$ 247,747	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WARREN PARK NURSING PAVILION # 0036079 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	127		1995		$ 2,698,750	$ 97,357	35	$	$ (97,357)	$	4
5			1993		26,835	688	35	767	79	6,389	5
6											6
7											7
8											8
	Improvement Type**										
9											9
10											10
11											11
12											12
13											13
14											14
15											15
16											16
17											17
18											18
19											19
20											20
21											21
22											22
23											23
24											24
25											25
26											26
27											27
28											28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A-REP, Line 70 for total

Facility Name & ID Number WARREN PARK NURSING PAVILION # 0036079 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
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56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,725,585	$ 98,045		$ 767	$ (97,278)	$ 6,389	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number WARREN PARK NURSING PAVILION # 0036079 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 456,656	$ 1,800	$ 12,347	$ 10,547	10	$ 73,765	71
72	Current Year Purchases	7,460	41	327	286	10	327	72
73	Fully Depreciated Assets	72,439				10	72,439	73
74								74
75	TOTALS	$ 536,555	$ 1,841	$ 12,674	$ 10,833		$ 146,531	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	FACILITY BUSINESS	DODGE - MIDWAY	1993	$ 21,583	$	$	$	5	$ 21,583	76
77	ALLOC DYNAMIC	ALLOC DYNAMIC	2001	3,406		185	185	5	185	77
78										78
79										79
80	TOTALS			$ 24,989	$	$ 185	$ 185		$ 21,768	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,251,193	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 130,774	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 52,645	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ (78,129)	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 416,046	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number WARREN PARK NURSING PAVILION # 0036079 Report Period Beginning: 01/01/01 Ending: 12/31/01

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [X] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [X] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [X] NO

16. Rental Amount for movable equipment: $ 7,329 Description: Water Cooler $133, Ice Machine $307, Dishwasher $715, Alloc Dynamic $6,174
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17	FACILITY	VOLVO	$ 554.75	$ 8,368	17
18					18
19					19
20					20
21	TOTAL		$	$ 8,368	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number WARREN PARK NURSING PAVILION # 0036079 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				Alloc.
7	Contractual Payments				Dynamic
8	Nurse Aide Competency Tests			100	100
9	TOTALS	$	$	$ 100	$ 100
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number WARREN PARK NURSING PAVILION # 0036079 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39 - 03	hrs	$		$ 14,446	$		$ 14,446	1
2	Licensed Speech and Language Development Therapist	39 - 03	hrs			1,474			1,474	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39 - 03	hrs			20,752			20,752	4
5	Physician Care		visits							5
6	Dental Care	39 - 03	visits			794			794	6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39 - 02	# of prescrpts				43,032		43,032	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):						24,681		24,681	13
14	TOTAL			$		$ 37,466	$ 67,713		$ 105,179	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number WARREN PARK NURSING PAVILION # 0036079 Report Period Beginning: 01/01/01 Ending: 12/31/01

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/01 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ (206,696)	$ (191,194)	1
2	Cash-Patient Deposits	73,294	73,294	2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	856,207	866,207	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	38,266	38,266	6
7	Other Prepaid Expenses	3,228	3,228	7
8	Accounts Receivable (owners or related parties)	561,268	552,255	8
9	Other(specify): See supplemental schedule	40,950	40,950	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,366,517	$ 1,383,006	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land		158,700	13
14	Buildings, at Historical Cost		2,698,750	14
15	Leasehold Improvements, at Historical Cost	759,181	1,076,681	15
16	Equipment, at Historical Cost	222,389	222,389	16
17	Accumulated Depreciation (book methods)	(339,217)	(1,089,579)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs	7,000	7,000	19
20	Accumulated Amortization - Organization & Pre-Operating Costs	(7,000)	(7,000)	20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):		(216,344)	22
23	Other(specify): See supplemental schedule	216,439	216,439	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 858,792	$ 3,067,036	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,225,309	$ 4,450,042	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 203,098	$ 203,098	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	73,294	73,294	28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	128,313	128,313	30
31	Accrued Taxes Payable (excluding real estate taxes)	2,447	2,447	31
32	Accrued Real Estate Taxes(Sch.IX-B)	124,000	124,000	32
33	Accrued Interest Payable	1,627	19,553	33
34	Deferred Compensation			34
35	Federal and State Income Taxes	3,109	3,109	35
	Other Current Liabilities(specify):			
36	See supplemental schedule			36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 535,888	$ 553,814	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	714,000	2,865,078	39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43	See supplemental schedule			43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 714,000	$ 2,865,078	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,249,888	$ 3,418,892	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 975,421	$ 1,031,150	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,225,309	$ 4,450,042	48

*(See instructions.)

Facility Name & ID Number WARREN PARK NURSING PAVILION # 0036079 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 827,451	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 827,451	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	274,970	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	(127,000)	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 147,970	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 975,421	24	*

*** This must agree with page 17, line 47.**

Facility Name & ID Number WARREN PARK NURSING PAVILION # 0036079 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 4,026,045	1
2	Discounts and Allowances for all Levels	(252,738)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 3,773,307	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	155,430	6
7	Oxygen	441	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 155,871	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	62,163	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	7,145	19
20	Radiology and X-Ray	203	20
21	Other Medical Services	49,120	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 118,631	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	30,309	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 30,309	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule	2,516	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 2,516	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,080,634	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	782,620	31
32	Health Care	1,262,096	32
33	General Administration	1,012,341	33
	B. Capital Expense		
34	Ownership	573,895	34
	C. Ancillary Expense		
35	Special Cost Centers	105,179	35
36	Provider Participation Fee	69,533	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 3,805,664	40
41	**Income before Income Taxes (line 30 minus line 40)****	274,970	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 274,970	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? Not Complete If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number WARREN PARK NURSING PAVILION # 0036079 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,960	2,080	$ 53,457	$ 25.70	1
2	Assistant Director of Nursing	2,443	2,635	56,984	21.63	2
3	Registered Nurses	17,297	18,554	331,773	17.88	3
4	Licensed Practical Nurses	5,475	6,082	91,943	15.12	4
5	Nurse Aides & Orderlies	50,620	55,327	430,177	7.78	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,904	2,024	23,097	11.41	9
10	Activity Assistants	6,864	7,162	50,139	7.00	10
11	Social Service Workers	8,826	9,486	89,280	9.41	11
12	Dietician					12
13	Food Service Supervisor	2,160	2,320	37,911	16.34	13
14	Head Cook	6,822	7,534	64,233	8.53	14
15	Cook Helpers/Assistants	12,017	12,745	88,374	6.93	15
16	Dishwashers					16
17	Maintenance Workers	2,600	2,768	49,973	18.05	17
18	Housekeepers	14,939	16,132	114,062	7.07	18
19	Laundry	5,135	5,463	35,675	6.53	19
20	Administrator	2,080	2,200	50,103	22.77	20
21	Assistant Administrator	2,883	3,083	60,011	19.47	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	7,650	7,970	84,262	10.57	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	68	68	540	7.94	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	151,743	163,633	$ 1,711,994 *	$ 10.46	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	188	$ 6,720	01-03	35
36	Medical Director	96	4,200	09-03	36
37	Medical Records Consultant	90	4,032	10-03	37
38	Nurse Consultant	43	1,504	10-03	38
39	Pharmacist Consultant	83	2,989	10-03	39
40	Physical Therapy Consultant	77	2,710	10a-03	40
41	Occupational Therapy Consultant	90	3,160	10a-03	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	60	3,218	11-03	44
45	Social Service Consultant	136	8,060	12-03	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	863	$ 36,593		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	383	$ 13,640	10-03	50
51	Licensed Practical Nurses				51
52	Nurse Aides	8	288	10-03	52
53	TOTAL (lines 50 - 52)	391	$ 13,928		53

Facility Name & ID Number WARREN PARK NURSING PAVILION # 0036079 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
JONATHAN GUTSTEIN	ADMINISTRATOR		$ 37,213
FROM 01/01 - 9/30			
SHEILA BOGEN	ADMINISTRATOR	14.96%	12,890
FROM 10/1 - 12/31			
JOCELYN LEDESMA	ASST. ADMINISTRATOR		60,011
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 110,114

B. Administrative - Other

Description	Amount
DYNAMIC HEALTHCARE - MANAGEMENT FEES	$ 26,640
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$ 26,640

C. Professional Services

Vendor/Payee	Type	Amount
FROST, RUTTENBERG &		$
ROTHBLATT	ACCOUNTING	13,655
DYNAMIC HEALTHCARE	ACCOUNTING	317
PERSONNEL PLANNERS	UNEMPLOYMENT CONS.	845
ECONOCARE	PURCHASE CONSULTANT	2,292
SACHNOFF & WEAVER,LTD.	LEGAL	8,446
FINKEL, MARTWICK&COLSON	LEGAL	2,017
HEALTH DATA SYSTEMS	DATA PROCESSING	2,630
DYNAMIC HEALTHCARE	BOOKKEEPING	188,260
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$ 218,462

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 33,129
Unemployment Compensation Insurance	11,819
FICA Taxes	130,357
Employee Health Insurance	161,837
Employee Meals	44,366
Illinois Municipal Retirement Fund (IMRF)*	
CHICAGO HEAD TAX	4,122
EMPLOYEE BENEFITS	19,223
TOTAL (agree to Schedule V, line 22, col.8)	$ 404,853

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 400
Advertising: Employee Recruitment	1,088
Health Care Worker Background Check	
(Indicate # of checks performed 23)	329
DUES, SUBSCRIPTIONS	3,838
LICENSES AND PERMITS	1,780
PROMOTION	8,418
CONTRIBUTIONS	3,075
ALLOC DYNAMIC	1,025
CONTRIBUTIONS	(3,075)
Less: Public Relations Expense	(8,418)
Non-allowable advertising	
Yellow page advertising	
TOTAL (agree to Sch. V, line 20, col. 8)	$ 8,460

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	3,260
ALLOC DYNAMIC	714
Entertainment Expense	
TOTAL (agree to Sch. V, line 24, col. 8)	$ 3,974

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number WARREN PARK NURSING PAVILION # 0036079 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
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16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number WARREN PARK NURSING PAVILION # 0036079 Report Period Beginning: 01/01/01 Ending: 12/31/01

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? yes

(2) Are there any dues to nursing home associations included on the cost report? YES
If YES, give association name and amount. IL COUNCIL $2,519

(3) Did the nursing home make political contributions or payments to a political action organization? YES If YES, have these costs been properly adjusted out of the cost report? YES

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? NO If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? YES
What was the average life used for new equipment added during this period? 10YRS

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 7,440 Line 10

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? YES If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? NO
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES X NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO X If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 69,533
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? NO If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? N/A

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? NO For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ 44,366 Has any meal income been offset against related costs? NO Indicate the amount. $

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? NO
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? NO If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? 100%ln14
d. Have vehicle usage logs been maintained? YES
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? NO
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? N/A
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ N/A

(17) Has an audit been performed by an independent certified public accounting firm?
Firm Name: N/A The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? YES

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? YES
Attach invoices and a summary of services for all architect and appraisal fees